STATE OF ARIZONA
FILED

OCT 17 2001

DEPT. OF INSURANCE
BY

STATE OF ARIZONA
DEPARTMENT OF INSURANCE

In the Matter of: **HUMANA HEALTH PLAN, INC.** **(NAIC No. 95885)** Respondent.	Docket No. 01A-241-INS CONSENT ORDER

A health care appeals audit was made of Humana Health Plan, Inc., hereinafter referred to as "Humana," by the Health Care Appeals Examiner for the Arizona Department of Insurance (the "Department") and was completed on August 20, 2001. The audit covered expedited medical review appeals, informal reconsideration appeals, formal appeals, and external independent review appeals from July 1, 1998 through December 31, 1999. Based upon the audit results, it is alleged that Humana has violated the provisions of A.R.S. §§20-461, 20-2533, 20-2524, 20-2535, 20-2536, and 20-2537.

The Examiner reviewed Humana's health care appeals procedures, expedited, informal, formal, and external health care appeals files, and other materials sent to the Department in response to the audit call letter.

Humana wishes to resolve these matters without formal adjudicative proceedings, admits the following Findings of Fact are true and consents to entry of the following Conclusions of Law and Order.

FINDINGS OF FACT

1. Humana is a Kentucky domiciled health care services organization. Humana is authorized to transact health insurance business pursuant to a certificate of authority issued by the Director.

2. The Examiner was authorized by the Director to conduct a heath care appeals audit of Humana and has prepared a Report of Examination of the Health Care Appeals of Humana ("the Report").

3. The Examiner reviewed Humana's survey response to the Department's appeals survey of June 1999 and found that Humana did not distribute approved appeals information packets to all new and in-force business until September 24, 1998.

4. The Examiner reviewed two expedited medical review appeals and found that each of the files contained one deficiency. The deficiencies are as follows:

a. Humana notified the member in one case of a timeframe within which it would render an expedited medical review decision that was inconsistent with the timeframe provided by law.

b. Humana failed to include the criteria used and clinical reasons for the decision in one decision letter.

5. The Examiner reviewed eight-six informal reconsideration appeals, ten of which were not subject to the Arizona health care appeals laws. Of the remaining seventy-six files, the deficiencies are as follows:

a. Humana failed to distribute information packets to the member in fifty-nine cases and to the provider in sixty-four cases.

b. Humana failed to send a written acknowledgement of the request for appeal to the treating provider in forty-five cases. In one additional case, Humana failed to send a written acknowledgement of the request for appeal to the member.

c. Humana failed to send written notice of the decision to the treating provider in fifteen cases. In one additional case, Humana failed to send written notice of the decision to the member.

d. Humana failed to notify members in twenty-six cases of the right to request a formal appeal following the informal reconsideration, and if the formal appeal is upheld, of the right to an external independent review.

e. Humana failed to include the criteria used and clinical reasons for the decision in twenty-seven appeal decision letters.

f. Humana failed to render a decision in four cases prior to sending the appeal for external independent review.

g. Humana failed to render a decision within 30 days of receiving the appeal request in eight cases.

h. Humana informed the member in three cases that an appeal needed to be made in writing within 30 days of the denial.

i. Humana required the treating provider in one case to complete an appointment of representative form that indicated that claim denials must be appealed under the standard 60-day appeal process, which conflicts with Humana's appeals information packet.

j. Humana required the treating provider in one case to complete an appointment of representative form in order to initiate an appeal.

k. Humana required the treating provider in one case to sign and return a "Provider Reconsideration Waiver" prohibiting the provider from billing the member for services if the appeal is denied.

l. Humana treated one case as an informal reconsideration, even though the member had previously appealed the denial.

6. The Examiner reviewed eleven formal appeals. The deficiencies are as follows:

a. Humana failed to send written acknowledgment to the treating provider within five business days of receiving the appeal request in nine cases.

b. Humana failed to send an information packet to the treating provider with the acknowledgement of the appeal in ten cases. In five additional cases, Humana failed to send an information packet to the member.

c. Humana failed to include the criteria used and clinical reasons for the decision in five appeal decision letters.

d. Humana failed to include notice of the right to request an external independent review following the formal appeal in one case that was only partially overturned.

7. The Examiner reviewed ten external independent review cases. The deficiencies are as follows:

a. Humana failed to include a complete copy of the evidence of coverage with one appeal sent to the Department for external independent review.

b. Humana failed to send written acknowledgment of the request for review to the treating provider in six cases. In two additional cases, Humana failed to send written acknowledgment of the request for review to the member.

c. Humana failed to send acknowledgment of the request for external independent review to the Department and failed to notify the Department of the reviewer selected in one case.

d. Humana failed to send a copy of the appeal decision to the treating provider in two cases.

e. Humana failed to send the Director a notice of the external reviewer's decision in one case.

f. Humana failed to send one external independent review decision to the member and treating provider within 30 days of receiving the appeal request.

g. Humana disclosed the names of the member and provider to the external independent reviewer in one case.

CONCLUSIONS OF LAW

1. Humana violated A.R.S. §20-2533(C) and §20-461(A)(17) by failing to distribute health care appeals information packets with newly issued policies.

2. Humana violated A.R.S. §20-2534(B) by failing to include the criteria used and clinical reasons for the decision in expedited medical review appeals.

3. Humana violated A.R.S. §20-2535(B) (1999) and §20-461(A)(17) by failing to send members and their treating providers acknowledgment letters and health care appeals information packets within five business days of receiving the appeal requests.

4. Humana violated A.R.S. §20-2535(D) and §20-461(A)(17) by failing to send the member and the member's treating provider a written notice of the decision within 30 days after receiving the request for appeal.

5. Humana violated A.R.S. §20-2535(F) and §20-461(A)(17) by failing to inform members of the right to request formal appeal following informal reconsideration, and if the formal appeal is upheld, of the right to an external independent review.

6. Humana violated A.R.S. §§20-2535(D), (F), and §20-461(A)(17) by failing to include the criteria and clinical reasons for its appeal denials in informal reconsideration decision letters.

7. Humana violated A.R.S. §20-2535(E) by failing to render decisions in informal reconsideration appeals prior to sending the appeals for external independent review.

8. Humana violated A.R.S. §20-2536(B) (1999) by failing to send acknowledgment letters of formal appeal requests and health care appeals information packets to members and their treating providers within five business days of receiving the appeal requests.

9. Humana violated A.R.S. §20-2536(E) by failing to include the criteria and clinical reasons for its appeal denial in formal appeal decision letters.

10. Humana violated A.R.S. §20-2536(G) by failing to inform a member of the right to an external independent review.

11. Humana violated A.R.S. §20-2537(C)(2)(b) by failing to include a copy of the evidence of coverage with an appeal send to the Department for external independent review.

12. Humana violated A.R.S. §20-2537(C)(1) (1999) by failing to send written acknowledgment of the request for review to the member, treating provider, and the Director, and by failing to notify the Director of the reviewer selected.

13. Humana violated A.R.S. §20-2537(D) (1999) by failing to send a copies of external independent review decisions to treating providers and members within 30 days of receiving the appeal request.

14. Humana violated A.R.S. §20-2537(D)(1)(b) (1999) by failing to send the Director a notice of the external reviewer's decision.

15. Humana violated A.R.S. §20-2537(H)(3) (1999) by disclosing the names of members and providers to external independent reviewers.

ORDER

IT IS HEREBY ORDERED THAT:

1. Within 90 days of the filed date of this Order, Respondent shall develop an action plan outlining procedures that will ensure the following:

a. Health care appeals information packets are distributed with all newly issued policies and certificates pursuant to A.R.S. §20-2533(C).

b. All denial letters will advise the member or treating provider of the correct information regarding the ability to appeal denials and the proper timeframes applicable to those appeals, consistent with A.R.S. §§20-2533(D), 20-2534(B), 20-2535(A) and 20-2536(A).

c. All expedited medical review acknowledgment letters will advise the member or provider of the appropriate timeframe within which a decision will be rendered, consistent with A.R.S. §20-2534(B).

d. All decision letters following the completion of expedited medical review appeals, informal reconsideration appeals, and formal appeals will include the criteria used and clinical reasons for the decision, consistent with A.R.S. §20-2534(B), §20-2535(D) and (F), and §20-2536(E).

e. All members and treating providers are sent written acknowledgment letters of requests for informal reconsiderations and formal appeals within five business days of receiving the appeal request pursuant to A.R.S. §§20-2535(B) and 20-2536(B).

f. All informal appeal decisions are rendered within 30 days of receiving the request for appeal pursuant to A.R.S. §20-2535(D).

g. All members and treating providers are sent a written notice of the decision following the completion of all informal reconsideration appeals pursuant to A.R.S. §20-2535(D).

h. All informal reconsideration decision letters that uphold the original denial will advise the member of the right to request a formal appeal, and if the formal appeal is upheld, of the right to request an external independent review, pursuant to A.R.S. §20-2535(F).

i. Determinations will be made before sending informal reconsideration appeals for external independent review, pursuant to A.R.S. §2535(E).

j. No appointment of representative forms will indicate that claim denials must be processed through the standard (formal) appeals process rather than the informal reconsideration process, unless so indicated in the Company's health care appeals packet.

k. No appointment of representative form will be required from the provider if the provider wishes to appeal a denial on behalf of a member, consistent with A.R.S. §§20-2533 and 20-2535(A).

l. No Provider Reconsideration Waiver form will be required by the Company from non-participating providers prior to acceptance of an appeal request from the provider, consistent with A.R.S. §§20-2533 and 20-2535(A).

m. All appeals-related correspondence will reference the appropriate appeal level.

n. All external independent review cases will include a complete copy of the evidence of coverage when sent for review, pursuant to A.R.S. §20-2537(C).

o. Written acknowledgments of all external independent reviews will be sent to the member, provider and Director, pursuant to A.R.S. §20-2537(C).

2. Within 90 days of the filed date of this Order, Respondent shall provide the Department with a copy of the action plan developed pursuant to Paragraph One of this section of the Order.

3. Humana shall pay a civil penalty of $10,000.00 to the Director for remission to the State Treasurer for deposit in the State General Fund in accordance with A.R.S. §20-220(B). Said amount shall be provided to the Health Care Appeals Section of the Department prior to the filing of this Order.

4. The Report of Examination dated August 20, 2001, and any objections to the Report submitted by Humana, shall be filed with the Department upon the filing of this Order.

DATED this 17th day of October, 2001.

Charles R. Cohen
Director of Insurance

CONSENT TO ORDER

1. Respondent, HUMANA HEALTH PLAN, INC. has reviewed the foregoing Order.

2. Respondent admits the jurisdiction of the Director of Insurance, State of Arizona, admits the foregoing Finding of Facts are true, and consents to the entry of the Conclusions of Law and Order.

3. Respondent is aware of the right to a hearing, at which it may be represented by counsel, present evidence and cross-examine witnesses. Respondent irrevocably waives the right to such notice and hearing and to any court appeals related to this Order.

4. Respondent states that no promise of any kind or nature whatsoever was made to it to induce it to enter into this Consent Order and that it has entered into this Consent Order voluntarily.

5. Respondent acknowledges that the acceptance of this Order by the Director of the Arizona Department of Insurance is solely for the purpose of settling this matter and does not preclude any other agency or officer of this state or its subdivisions or any other person from instituting proceedings, whether civil, criminal, or administrative, as may be appropriate now or in the future.

6. Sharon E. Ware, who holds the office of Vice President of Respondent, is authorized to enter into this Order for it and on its behalf.

HUMANA HEALTH PLAN, INC.

10/12/01
(date)

By Sharon E. Ware
Sharon E. Ware, Vice President

COPY of the foregoing mailed/delivered this 17th day of October, 2001 to:

Sara Begley
Deputy Director

Vista Brown
Executive Assistant
Gerrie Marks
Executive Assistant
Catherine O'Neil
Consumer Legal Affairs Officer/Custodian of Records
Mary Butterfield
Assistant Director
Consumer Affairs Division
Alexandra Shafer
Assistant Director
Life and Health Division
Deloris E. Williamson
Assistant Director
Rates & Regulations Division
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